Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Hopkinson, a prisoner at HMP Manchester, on 17 February 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Lee Hopkinson was found hanged in his cell at HMP Manchester on 17 February 2022. Toxicology results established that he had alcohol in his system at a level of intoxication. Mr Hopkinson was 33 years old. I offer my condolences to his family and friends.

I am satisfied that Mr Hopkinson received appropriate mental healthcare at Manchester. While he had a long history of substance misuse, there is no evidence that he was at imminent risk of suicide or self-harm in the days before his death.

It is troubling that Mr Hopkinson was able to access alcohol and other illicit substances with apparent ease at Manchester. While Manchester has taken some steps to reduce alcohol and drug supply, this case is a clear indicator that more still needs to be done to reduce the availability of drugs and alcohol.

Around seven weeks before his death, Mr Hopkinson was assaulted, seemingly as a result of debts that he had accrued. I am not satisfied that this was properly investigated.

I am also concerned about the lack of wellbeing checks completed for Mr Hopkinson and a delay in calling the emergency response when he was found hanged.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **February 2023**

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Summary

Events

1. In February 2019, Mr Lee Hopkinson was remanded in custody to HMP Forest Bank, charged with manslaughter. In August, he was convicted and sentenced to 13 years in prison. Mr Hopkinson was subsequently transferred to HMP Manchester.

2. Mr Hopkinson had a history of attempted suicide, self-harm and substance misuse. Between February and December 2019, prison staff monitored Mr Hopkinson under suicide and self-harm procedures, known as ACCT. Mr Hopkinson was often suspected of using illicit drugs at Manchester, and he lived on a wing for prisoners who are trying to live drug-free. While Mr Hopkinson largely engaged with the drug and alcohol service, his substance misuse continued sporadically.

3. On 29 December 2021, Mr Hopkinson presented with injuries consistent with an assault. Security intelligence indicated that he had accumulated debts, although Mr Hopkinson denied this.

4. At 8.30am on 17 February 2022, an officer found Mr Hopkinson hanged in his cell. Staff radioed a medical emergency code blue, indicating a life-threatening situation. They did not try to resuscitate Mr Hopkinson as it was clear that he had been dead for some time. A toxicology examination found that Mr Hopkinson had drunk a significant amount of alcohol before his death.

Findings

Identifying the risk of suicide and self-harm

5. While Mr Hopkinson had some risk factors for suicide and self-harm, we consider that there was little to indicate to staff that he was at immediate risk of suicide and self-harm at the time of his death.

Mr Hopkinson's use of illicit substances

6. We are concerned that Mr Hopkinson was able to access drugs and alcohol in the prison with apparent ease. Although Manchester has taken some steps to address its drug supply issues, Mr Hopkinson's death is a reminder that more needs to be done to reduce the availability of drugs and alcohol and increase their detection. The availability of illicit substances remains a problem across the whole prison estate and should remain a priority for Manchester.

7. We are concerned that prison staff failed properly to investigate intelligence that Mr Hopkinson was assaulted as a result of a debt.

Meaningful contact with prisoners

8. Prison staff did not carry out any keywork sessions or wellbeing checks on Mr Hopkinson from July 2021.

Emergency response

9. When staff found Mr Hopkinson unresponsive in his cell, there was a delay of about two minutes before a medical emergency code was called. This delay did not affect the outcome for Mr Hopkinson as he had been dead for some time when he was found, but it could make a significant difference in another emergency.

Recommendations

- The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated, that apparent victims are effectively supported and protected, and that appropriate punitive measures are used to manage prisoners who display challenging behaviour.

- The Governor should ensure that staff have regular, meaningful interaction with the prisoners in their care and conduct weekly wellbeing checks.

- The Governor and the Head of Healthcare should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to communicate the nature of an emergency effectively.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners contacted the investigator.

11. The investigator obtained copies of relevant extracts from Mr Hopkinson's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Hopkinson's clinical care at the prison.

13. The investigator and clinical reviewer jointly interviewed eight members of staff at Manchester. The interviews were completed in person and by video link.

14. We informed HM Coroner for Manchester City of the investigation. He provided us with a copy of the post-mortem report. We have sent him a copy of this report.

15. The Ombudsman's family liaison officer wrote to Mr Hopkinson's father and partner to explain the investigation. Mr Hopkinson's father told us that his son had been in good spirits a few days before he died and did not think that he sounded like someone who was planning to take their own life. Mr Hopkinson's father asked for details of the events leading to his son's death. He also asked the following questions:

    - Mr Hopkinson was assaulted by a number of prisoners in the showers the day before his death. Was there CCTV footage of this incident?
    - Was Mr Hopkinson being monitored by suicide and self-harm procedures?
    - How was Mr Hopkinson found when he was discovered hanged in his cell?
    - Why did prison staff not immediately tell him that Mr Hopkinson had written suicide notes?

16. Mr Hopkinson's father and family legal representative received a copy of the initial report. Mr Hopkinson's father wrote to us raising a number of issues that did not impact on the factual accuracy of this report.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified one factual inaccuracy which has been amended in the final report. All recommendations were accepted.

Background Information

HMP Manchester

18. HMP Manchester is a high security training prison which accepts long-term prisoners. There is a Category A unit for prisoners posing greater security risks. The prison holds up to 744 prisoners in nine residential units, a segregation unit, specialist intervention unit and a healthcare unit. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing care.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Manchester was in September 2021. Inspectors found that since the previous inspection, there had been five self-inflicted deaths, including two in the six months before the inspection. There had also been five deaths that had not been from natural causes, two of which were drug-related and in three the cause of death was unascertained. There were continuing concerns about the use of illicit substances and the prison had held a consultation forum known as the 'drug summit' with staff and prisoners where concerns were identified, and an action plan was drawn up. They had also undertaken an associated survey, where the views of prisoners and staff were sought to help address the use of illicit drugs.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 28 February 2021, the IMB reported that the COVID-19 pandemic had affected the prison regime, with education, association, gym access and workshops not being available, and prisoners therefore spending long periods of time in their cells. The IMB also reported that Manchester had experienced the continued use of drugs by prisoners across wings. Prison staff had had used the intelligence received about the location of drug detections to target specific wings and disrupt activity by transferring prisoners identified as the intended recipients of drug packages to other wings.

Previous deaths at HMP Manchester

21. Mr Hopkinson was the third prisoner to take his life at Manchester since January 2020. There has since been one further self-inflicted death at the prison. There were no notable similarities between Mr Hopkinson's death and the first death that occurred in this period. We are still investigating the other two self-inflicted deaths.

Assessment, Care in Custody and Teamwork

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be

irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary reviews involving the prisoner.

23. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

COVID-19 restrictions

24. On 24 March 2020, in response to the COVID-19 pandemic and in line with Government advice, HM Prison and Probation Service (HMPPS) issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected Government restrictions following the national lockdown. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent much of their day locked behind their cell doors. On 17 September 2021, the Government advised that it was no longer necessary for the clinically vulnerable to shield. This was on the basis that vaccination had reduced the risk to them.

Keyworker scheme

25. The keyworker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a dedicated keyworker who will spend an average of 45 minutes a week on keywork activities, including having meaningful conversation which each of their allocated prisoners.

26. The keyworker scheme was suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, such as those who were at risk of suicide or self-harm, the Prison Service introduced the Exceptional Delivery Model for keywork in May 2020. This provides that an officer will have a weekly conversation with prisoners identified as vulnerable.

Key Events

27. On 18 February 2019, Mr Lee Hopkinson was remanded to HMP Forest Bank, charged with manslaughter. This was not his first time in prison. He had a history of violent offending, alcohol and drug misuse, attempted suicide, self-harm and depression. Between February and August 2019, prison staff monitored Mr Hopkinson under suicide and self-harm procedures, known as ACCT, on two occasions.

HMP Manchester

28. On 5 August 2019, Mr Hopkinson was found guilty of manslaughter, and was transferred to HMP Manchester.

29. During his reception screen, prison staff noted that Mr Hopkinson was being monitored by ACCT procedures and had been prescribed mood stabilizers. He was granted Own Protection (OP) status because he feared for his safety following threats to his life from his co-defendant. Staff arranged for him to be located in a single cell on a separate wing to his co-defendant.

30. A reception nurse completed Mr Hopkinson's health screen. Mr Hopkinson said that he wanted protection because there was a "price on his head" for his use of psychoactive substances (PS) such as Spice. Mr Hopkinson said that he had no current thoughts of self-harm. The nurse recorded that he had a history of anxiety, depression and post-traumatic stress disorder (PTSD) following previous self-harm (in June). The nurse referred Mr Hopkinson to the mental health team.

31. The next day, staff completed an ACCT case review. The ACCT case manager arranged for Mr Hopkinson to be located on K Wing as an OP prisoner. Appointments were made for Mr Hopkinson to see the prison GP and the psychiatrist. (Prison staff closed the ACCT procedures on 19 August.)

32. Prison staff recorded that Mr Hopkinson was not allowed to keep his prescribed medication in his cell and it would be administered by healthcare staff when due.

33. On 13 August, Mr Hopkinson was sentenced to 13 years in prison.

34. From August to November, staff found Mr Hopkinson under the influence of illicit substances on several occasions and his behaviour was poor. He was placed on the basic level of the prison's Incentive and Earned Privileges (IEP) scheme. (The IEP scheme is designed to encourage positive and constructive behaviour.)

35. On 27 September, a consultant psychiatrist diagnosed Mr Hopkinson with emotionally unstable personality disorder (EUPD). She prescribed quetiapine, an antipsychotic. She noted that Mr Hopkinson's previous self-harm and suicide attempts were often reactive and impulsive. Mr Hopkinson said that he had tried to take his life at Forest Bank and had left suicide notes, although he could not recall why he had wanted to end his life. He said that he did not want to die.

36. On 5 December, the consultant psychiatrist reviewed Mr Hopkinson, who reported that he felt stable and had no thoughts of self-harm. It was agreed that he would be allowed to keep and administer seven days of medication.

37. On 6 December, Mr Hopkinson told staff that he had intentionally taken an overdose of his prescribed medication because he had accrued drug debts. Staff started ACCT procedures. Mr Hopkinson was given support for his debt and was moved to A Wing and then K Wing. On 27 December, staff ended ACCT monitoring.

2020

38. Over several months, staff identified a number of instances when Mr Hopkinson behaved poorly. He was found soliciting his and other prisoner's prescribed medication and failed to follow staff instructions several times. His poor behaviour led to him being placed on the basic IEP level on four occasions.

39. On 8 October, Mr Hopkinson reported that his medication (quetiapine) was not as effective as he wished. A consultant psychiatrist prescribed promethazine as an alternative. (Promethazine is an antihistamine and antipsychotic.)

40. During October, Mr Hopkinson was moved to A Wing. Staff noted no change to his poor behaviour despite their efforts to support him. They suspected his continuing involvement in the illicit drug trade on the wing and, once again, staff issued warnings and reduced his IEP level to basic. While Mr Hopkinson said that he feared for his safety from several prisoners, staff observed no evidence of this based on his presentation and how he continued to socialise with other prisoners.

41. On 5 November, Mr Hopkinson told the psychiatrist that his medication worked and that he had no thoughts of harming himself. He denied using illicit substances. Mr Hopkinson said that he had a prison job and was focused on trying to obtain re-categorisation to a Category C prisoner. Mr Hopkinson was discharged from mental health team caseload. His medication would continue to be prescribed.

42. In December, following an intelligence search of Mr Hopkinson's cell, staff found a quantity of medication that did not belong to him. They concluded that this meant that he had either bought the medication from other prisoners or bullied them for it. Mr Hopkinson was moved to B Wing and his OP status was removed.

2021

43. In January, after a period of improved behaviour, Mr Hopkinson's IEP level reverted to standard. However, security intelligence came to light that he may be under threat from another prisoner due to issues related to his co-defendant and drugs. Mr Hopkinson was moved to G Wing at the end of January. (G Wing is the drug and alcohol recovery unit and incentivised substance free living unit for prisoners wishing to curtail their addition to illicit substances. The prison's Drug and Alcohol Recovery Service (DARS) team are based in this unit and provide a mixture of one-to-one and group sessions with prisoners.)

44. Mr Hopkinson's DARS substance misuse recovery practitioner continued to support him to remain drug-free. This included delivering formal one-to-one sessions with him, as well as wellbeing checks in which she sought to identify his risks.

45. On 12 April, an officer noted that Mr Hopkinson had settled on G Wing and interacted well with staff. His IEP level was returned to standard, and he engaged with in-cell education.

46. On 7 and 21 May, staff again found Mr Hopkinson under the influence of illicit substances. He was given a prison warning and his IEP level was reduced to basic.

47. On 28 May, at a keywork session, Mr Hopkinson reported no concerns and said that the DARS team continued to support him.

48. On 11 June, staff found seven prisoners, including Mr Hopkinson, under the influence of illicit substances. Mr Hopkinson remained on basic IEP level, and staff noted that his television would be removed if his behaviour failed to improve. A member of the DARS team saw Mr Hopkinson the next day and gave him harm reduction advice.

49. Four days later, Mr Hopkinson was again found under the influence of drugs. Staff removed his television (which was returned to him on 23 June). Mr Hopkinson said that he found it difficult to remain drug-free.

50. On 17 June, the recovery practitioner saw Mr Hopkinson and completed a substance misuse review and wellbeing check. She discussed with him the high risk of overdose should he use different types of illicit substances and updated his DARS recovery care plan, noting that he presented well and was happy to continue to participate in the DARS recovery and support groups.

51. Over the following weeks, Mr Hopkinson appeared to settle on G Wing. He said that he had not used illicit substances and was not found under the influence of drugs. He continued to attend DARS recovery and support groups. Mr Hopkinson's IEP was reinstated to the standard level.

52. On 19 September, staff found fermenting liquid (hooch) in Mr Hopkinson's cell. His IEP was reduced to the basic level (until 14 October).

53. On 6 October, the recovery practitioner reviewed Mr Hopkinson. She discussed with him his recent intent to use hooch, the risks of doing so and the support available. Mr Hopkinson said that he planned to apply to HMP Grendon as they offered therapeutic community support. She helped him with his application.

54. On 11 October, Mr Hopkinson said that he had bought co-codamol from other prisoners on the wing, which had caused him to have an allergic reaction. The healthcare team noted that Mr Hopkinson was no longer allowed to keep his medication in his cell.

55. On 15 October, the recovery practitioner reviewed Mr Hopkinson. She discussed his use of illicitly obtained prescription medication and the risks associated with this.

56. In October and November, while no significant evidence was found, staff again suspected Mr Hopkinson was brewing hooch due to a suspicious smell in his cell. He continued to attend weekly DARS support group sessions.

57. On 8 November, the recovery practitioner saw Mr Hopkinson and discussed his welfare, relapse prevention and support group attendance. Mr Hopkinson said that he was doing well.

58. Throughout December, Mr Hopkinson continued to attend weekly DARS support group sessions. At his DARS review on 9 December, Mr Hopkinson said that he had stopped using drugs and alcohol but was struggling. The recovery practitioner gave him advice.

59. A nurse specialist practitioner met Mr Hopkinson on 15 December. She noted that he had recently tested positive for illicit buprenorphine (an opioid medication used to treat severe pain or for withdrawal from opioid based drugs). Mr Hopkinson said that he had used illicit substances since 2019. He was adamant that he wanted to complete a rapid detoxification so that he could stop using illicit substances. It was agreed that he would start a 14-day detoxification programme and was prescribed subutex (buprenorphine).

60. On 19 December, staff gave Mr Hopkinson a prison warning after he was found with a piece of paper suspected of being soaked in PS and an improvised smoking device.

61. On 24 December, a member of the healthcare team suspected that Mr Hopkinson was under the influence of an illicit substance due to the redness of his eyes. That day, the recovery practitioner completed a DARS review and wellbeing check with him. Mr Hopkinson denied that he had used illicit substances that day. She reminded Mr Hopkinson that if he did so, he would be removed from the detoxication programme due to the risk to his health of using multiple drugs.

62. On 29 December, an officer noticed that Mr Hopkinson appeared to have been assaulted as he had two black eyes. Mr Hopkinson refused to discuss the matter and stated he did not need medical intervention.

63. On 31 December, security intelligence was submitted that suggested that Mr Hopkinson's injury was sustained as a result of him accumulating debt related to his use of vapes. No further information was reported about the actual assault.

2022

64. On 10 January 2022, the recovery practitioner saw Mr Hopkinson to review his care plan. Mr Hopkinson said that since completing his detoxification, he had used illicit substances because he had problems sleeping. He said that he had attention deficit hyperactive disorder (ADHD) and that this was getting worse. She reminded Mr Hopkinson of the high risk of overdose. She referred him to the mental health team to review his ADHD and booked him in to attend the next DARS Reduction and Motivation Programme (RAMP) session.

65. On 11 January, Mr Hopkinson attended a RAMP session. That day, the healthcare multidisciplinary team meeting reviewed the recovery practitioner's referral relating

to Mr Hopkinson's ADHD. Mr Hopkinson was not prescribed medication for ADHD. The multidisciplinary team did not consider an appointment with a psychiatrist was needed at that time. It was also documented in his clinical notes that Mr Hopkinson had previously been assessed by two independent psychiatrists, neither of whom considered him to have ADHD symptoms. The multidisciplinary team agreed that Mr Hopkinson did not need additional mental health intervention at the time.

66. On 12 January, staff suspected that Mr Hopkinson was under the influence of PS.

67. The next day, the recovery practitioner spoke to Mr Hopkinson who admitted using PS sporadically since Christmas. He also said that he did not know how to manage his ADHD symptoms and felt that this affected his sleep. She explained to Mr Hopkinson that his sporadic substance misuse would have heightened his feelings and that he should refrain from taking illicit substances. Mr Hopkinson said that he struggled being locked in his cell and wanted a job.

68. That evening, healthcare staff withheld Mr Hopkinson's medication after he appeared under the influence of drugs when he attended the medication hatch.

69. On 14 January, the recovery practitioner reviewed Mr Hopkinson who said that he was not under the influence of drugs the previous day and that his presentation was due to a lack of sleep.

70. That afternoon, staff suspected that Mr Hopkinson was under the influence of drugs. They found a smoking pipe in his cell. Staff reduced his IEP level to basic and advised him that if his poor behaviour continued, he would be moved to a different wing.

71. On 19 January, staff noted that Mr Hopkinson would remain on basic IEP level for another month due to his recurring involvement in the illicit substance culture on G Wing. That day, Mr Hopkinson tested positive for COVID-19. (He completed a period of isolation during which no concerns were noted.)

72. On 28 January, Mr Hopkinson attended a PS awareness group, and, on 1 February, he attended a RAMP session.

73. On 2 February, the recovery practitioner saw Mr Hopkinson after he reported that he had been struggling with his ADHD. She noted that Mr Hopkinson engaged well. His Category C status review was coming up, and he wanted to speak to his offender manager. She told him that she had spoken to the offender manager unit and was awaiting a response from them about his review. She told Mr Hopkinson that she had spoken to the mental health team who had confirmed that he was second on the waiting list to see a psychologist.

74. On 3 February, Mr Hopkinson attended his RAMP group session. Staff recorded that he engaged well.

75. On 14 February, a Categorisation Review Board noted that Mr Hopkinson's recategorisation to Category C status was not approved. The Board noted that Mr Hopkinson should continue to work with the DARS team in an attempt to break his cycle of poor behaviour relating to his illicit substance misuse. Given that he had spent a period of time on the basic IEP level, they noted that an improvement in his behaviour was needed before he would be considered for recategorisation.

76. On 15 February, Mr Hopkinson attended a RAMP group session. That day, he used his in-cell PIN phoned and spoke to his aunt. Mr Hopkinson raised no issues to suggest that he was struggling or had thoughts of harming himself.

77. At around midday on 16 February, Mr Hopkinson made two phone calls from his in-cell phone. First, he spoke to his partner and said that he had drunk alcohol. He mentioned his recent recategorisation review. Mr Hopkinson also alluded to being assaulted by five prisoners in the showers the previous day, following a disagreement. In his second call to his aunt, Mr Hopkinson again said that he had been drinking and wanted to talk to someone. He talked about being assaulted and said that he wanted to plan some form of retaliation. His aunt tried to dissuade him from this. Mr Hopkinson also spoke about having sleeping problems. (There is no record that Mr Hopkinson reported an assault to prison staff at the time. There is no CCTV coverage of the area. Since Mr Hopkinson's death, prison staff have identified a prisoner whom they believe assaulted him.)

78. That afternoon, Mr Hopkinson attended a DARS recovery group meeting. After the session, Mr Hopkinson was observed socialising with other prisoners in the exercise yard, laughing and joking.

79. At around 5.30pm, staff suspected that Mr Hopkinson was brewing hooch due to the smell of fermenting liquid coming from his cell. Two officers searched Mr Hopkinson's cell but found nothing. Mr Hopkinson was at the medication hatch at the time.

80. When Mr Hopkinson returned to his cell, he pressed his cell bell. An officer attended his cell. Mr Hopkinson said that staff had trashed his cell during their search. The officer recorded that Mr Hopkinson was not happy, got frustrated and called her a "slag". He noted that Mr Hopkinson did not appear under the influence of drugs or alcohol. Mr Hopkinson said that he intended to inform his solicitor.

81. At 7.34pm, CCTV footage shows that an officer checked on Mr Hopkinson through his cell observation panel during his evening roll check (a count of prisoners). He did not record any concerns.

17 February

82. At 5.04am, during the early morning roll check, an Operational Support Grade (OSG) opened Mr Hopkinson's cell observation panel, using his torch to check him. The OSG said that Mr Hopkinson was not in his bed, but he saw his feet in the toilet area behind the privacy curtain at the back of the cell. He believed that Mr Hopkinson was okay and was standing up, using the toilet to urinate. He confirmed that he could not see anything, other than Mr Hopkinson's feet, which he said were at floor level. He then continued with his roll check at the next cell.

83. The OSG's duty ended at around 7.45am, and he recorded no concerns about Mr Hopkinson when he handed over to the day duty staff.

84. At 8.27am, Officer A and Officer B arrived on Mr Hopkinson's landing to conduct a welfare check of prisoners and to unlock specific prisoners to collect their medication. At interview, Officer A said that she simultaneously unlocked Mr Hopkinson's cell door while she looked through the observation panel and shouted

inside to alert him to collect his medication. She saw that Mr Hopkinson was standing or leaning at the back of his cell behind the privacy curtain with only the back of his legs visible. She believed that he was using the toilet and moved on to unlock the next cell. Mr Hopkinson's neighbour went to Mr Hopkinson's cell, as they would normally walk together to collect their medication. He saw that something was wrong and alerted Officer A.

85. Officer A returned to Mr Hopkinson's cell. When she went in, she saw Mr Hopkinson with a ligature (made from a bed sheet) around his neck, attached to the end of his bed. She shouted for staff assistance and cut the ligature. She said that she panicked and was shocked and therefore did not use her radio to call an emergency code at that time. She left the cell and walked onto the landing where, in less than five seconds, Officer B met her. She told Officer B that Mr Hopkinson was dead. At interview, Officer B told us he went into the cell and checked Mr Hopkinson for signs of life. He said that Mr Hopkinson was cold, rigid and had signs of rigor mortis which indicated that he had been dead for some time.

86. Officer B left the cell immediately (closing the door behind him). He was not carrying a radio and so informed a Supervising Officer (SO), who was on the wing landing. The SO told us that as an emergency alarm had not been raised, he radioed a medical emergency code blue, indicating a life-threatening situation. The control room log recorded that this occurred at 8.30am and that they called an ambulance.

87. At 8.33am, two nurses arrived at the cell, with medical emergency equipment. One nurse said that Mr Hopkins was slumped in a seated position. On examination, she found no pulse, a high degree of blood pooling, mottled skin and that Mr Hopkinson was stiff and cold. The nurses agreed that Mr Hopkinson had clearly been dead for some time. As a result, they did not try to resuscitate him. One nurse said that she saw a cannister on Mr Hopkinson's cupboard which looked like it may have had a liquid in it, possibly hooch.

88. At 8.55am, paramedics arrived at the cell and confirmed that Mr Hopkinson had died.

Contact with Mr Hopkinson's family

89. Mr Hopkinson listed his partner and father as his next of kin. At 12.00pm, the prison family liaison officer (FLO) and the Deputy Governor visited Mr Hopkinson's partner's home, but no one was there.

90. The FLO made several unsuccessful attempts to reach Mr Hopkinson's partner by telephone. Unsuccessful attempts were also made to contact Mr Hopkinson's parents by telephone. Mr Hopkinson's sister then telephoned the prison, and staff broke the news of Mr Hopkinson's death to her and offered support. Mr Hopkinson's sister said that she would inform other family members, including her father.

91. The FLO spoke to Mr Hopkinson's partner by telephone at around 5.00pm. (Mr Hopkinson's partner was already now aware of his death.)

92. The FLO maintained contact with Mr Hopkinson's family and, in line with national instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

93. The duty governor held a debrief with prison staff involved in the emergency response. All staff were offered the support of the prison's care team.

94. The Governor posted notices informing other prisoners of Mr Hopkinson's death and offering support in case they had been adversely affected.

Post-mortem report

95. A post-mortem examination identified Mr Hopkinson's cause of death as hanging. Post-mortem toxicology tests found alcohol in his system at a level associated with intoxication in a normal social drinker. It added that while alcohol would not have had a direct bearing on the cause of Mr Hopkinson's death, it may have influenced his actions and affected his judgement before his death.

Information received after Mr Hopkinson's death

96. After Mr Hopkinson's death, a number of prisoners came forward with information to suggest that Mr Hopkinson was being bullied on the wing. An investigation followed and two prisoners were relocated to different wings.

97. On 2 March, during a clearance of Mr Hopkinson's cell, staff found five letters in the pocket of a jacket he owned. The letters were short and addressed to his brother, father and family. The letters included that Mr Hopkinson loved his family, that he was sorry and that "my head is gone and [no] one can help me".

Findings

Identifying the risk of suicide and self-harm

98. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

99. Mr Hopkinson had a number of risk factors for suicide and self-harm. He had a history of PTSD, depression and a history of substance misuse. Mr Hopkinson had been monitored by ACCT procedures several times and he said that he had tried to take his life in 2019. There is evidence that Mr Hopkinson was bullied by other prisoners. While he refused to discuss this with staff, we are not satisfied that this was acknowledged or investigated as it should have been.

100. While Mr Hopkinson had these risk factors, we are satisfied that there was little to indicate to staff that he was at immediate risk of suicide and self-harm at the time of his death.

Mr Hopkinson's use of illicit substances

101. The post-mortem examination and toxicology results established that Mr Hopkinson was intoxicated with alcohol before his death. The pathologist noted that this may have influenced his actions and affected his judgement

102. There was an enormous amount of evidence that Mr Hopkinson used illicit substances while at Manchester. We are satisfied that staff made Mr Hopkinson aware of the potentially fatal risk of continuing to misuse drugs and alcohol and that he was offered support to stop. The clinical reviewer found that he engaged well with the DART service and identified no concerns with the care provided by the substance misuse team at Manchester.

Drug strategy at HMP Manchester

103. It is troubling that Mr Hopkinson was frequently able to access alcohol and other illicit substances in prison. We note that both HM Inspectorate of Prisons (HMIP) and the Independent Monitoring Board (IMB) have expressed concern about the ready availability of drugs at Manchester.

104. In April 2019, HM Prison and Probation Service (HMPPS) issued a national instruction that all prisons should review their drug strategies. Since this date, Manchester has implemented a new drug and alcohol strategy that focused on reducing the supply of and demand for drugs and in building recovery for those who use illicit substances. This strategy was further reviewed after Mr Hopkinson's death in April 2022.

105. We note that Manchester has taken some positive actions to reduce the supply of and demand for drugs, including consulting prisoners. Nevertheless, we are

concerned by the ease with which Mr Hopkinson was able to obtain illicit drugs and alcohol and it is apparent that the prison must continue to work hard towards reducing supply and demand.

Mr Hopkinson's debt and bullying issues

106. Following his death, some prisoners told staff that Mr Hopkinson was being bullied for vapes. Shortly before his death, he told his family by telephone that he had been assaulted. When he lived on G Wing, Mr Hopkinson had never reported to prison staff or members of the DARS team that he was in debt, had been assaulted or that he feared for his safety due to his illicit substance misuse.

107. Around seven weeks before his death, prison staff identified that Mr Hopkinson had been assaulted. Although he refused to discuss the matter, we note that security intelligence indicated that Mr Hopkinson was assaulted as a result of debts that he had accumulated. There is no evidence that this incident was properly investigated or referred to the violence reduction team. This was a missed opportunity to support Mr Hopkinson and identify any potential violence and bullying issues he might have been experiencing.

108. Manchester has a local violence reduction policy (last reviewed May 2021) which states that they will identify and support those who are victims of violence. This should include those who are under threat of violence due to bullying or debt. Manchester's local policy states that they will look at all violent incidents and aims to make sure that all incidents have been reported correctly and that investigations and actions are being taken.

109. We recognise that after Mr Hopkinson's death, the prison investigated allegations that he was being bullied, which resulted in two prisoners being moved to different wings. However, this action alone does little to fully address the root cause of bullying and the prison needs to ensure that, in line with its violence reduction policy and in cases such as this, meaningful action is taken to ensure that such behaviour is not repeated.

110. We make the following recommendation:

The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated, that apparent victims are effectively supported and protected, and that appropriate punitive measures are used to manage prisoners who display challenging behaviour.

Meaningful contact with prisoners

111. In June 2020, Manchester restricted keywork to priority groups. Manchester was categorised as a COVID-19 outbreak site on four occasions over the following 18 months and they only managed to progress to another stage of regime delivery twice (in November and December 2020 and in April 2021). Prison staff told us that due to high levels of staff sickness, they struggled to deliver monthly keywork sessions throughout this period, so they continued to focus on the most vulnerable prisoners.

112. We agree that Mr Hopkinson did not fall into the priority group to receive weekly keywork. (Such prisoners include those who are being monitored under ACCT procedures or who have particularly challenging mental health needs.) Instead, he received keywork sessions approximately monthly. However, from July 2021 there is no record that staff completed any keywork sessions or wellbeing checks. We appreciate the difficulties that COVID-19 presented in terms of maintaining meaningful interaction between staff and prisoners, and we note that the DARS team offered regular contact and support to Mr Hopkinson. However, we are concerned that the lack of regular keywork and wellbeing checks on Mr Hopkinson was a missed opportunity to identify his needs and recognise potential difficulties on the wing. We make the following recommendation:

The Governor should ensure that staff have regular, meaningful interaction with the prisoners in their care and conduct weekly wellbeing checks.

Emergency response codes

113. It is possible that Mr Hopkinson was hanging at the time of the morning roll check on 17 February. The investigator viewed Mr Hopkinson's cell and identified that the bed was fully visible from the cell door hatch, as well as a privacy curtain which separated the bed from the toilet. At the time that the morning roll check was completed, it would have been dark and although the officer used a torch to help him see, it still would have been difficult to see a ligature clearly. The OSG told us that, on reflection, given the obscured view due to the privacy curtain, Mr Hopkinson might have been hanging when he completed his roll check. Without additional evidence, it is not possible to know if this was the case.

114. PSI 03/2013 on medical emergency response codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for Governors and Directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It states that if an emergency code is radioed, an ambulance must be called immediately.

115. When Officer A discovered Mr Hopkinson hanging, she quickly cut the ligature. However, she did not radio an emergency code blue. There was a delay of approximately two minutes before the SO radioed a code blue and an ambulance was called. While this delay made no difference to the outcome, as Mr Hopkinson had been dead for some time, in another emergency, such a delay could be critical. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency.

Inquest

116. The Coroner's inquest held on 11 December 2023 determined the medical cause of death to be hanging. The jury returned a narrative conclusion, stating that Mr Hopkinson died as a result of suicide and noted that it was probable that emotionally unstable personality disorder and a level of intoxication contributed to Mr Hopkinson hanging himself via ligature around the neck.

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